

Division of Licensing and Protection  
103 South Main Street, Ladd Hall  
Waterbury VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 871-3317  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 871-3318

October 11, 2012

Jeanne McLaughlin, Administrator  
Vna Of Vt & Nh  
1 Hospital Court  
Bellows Falls, VT 05101

Provider ID #:477002

Dear Ms. McLaughlin:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 24, 2012**.

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,



Pamela M. Cota, RN  
Licensing Chief

PC:jl

Enclosure



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/28/2012  
FDRM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  477002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/24/2012
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NAME OF PROVIDER OR SUPPLIER  VNA OF VT & NH	STREET ADDRESS, CITY, STATE, ZIP CODE 1 HOSPITAL COURT BELLOWS FALLS, VT 05101
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS	G 000		
G 143	484.14(g) COORDINATION OF PATIENT SERVICES  All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.  This STANDARD is not met as evidenced by: Based on record review and interview staff failed to coordinate services for 1 applicable client. (Client #1) Findings include:  1. Per record review on 9/24/12, Client # 1 was sent to the emergency room on 06/07/12 for a wound that deteriorated. A case communication note dated 06/10/12 stated that follow up with the physician was needed when the patient returned from the hospital. There is no documentation that the physician was contacted for further orders or changes to the treatment plan. In addition, the physician was not made aware that the client was not performing the wound dressing daily. Per interview on 09/24/12 at 1:30 PM the clinical coordinator manager confirmed there was no coordination between staff and physician regarding the follow up wound care and lack of daily treatments..	G 143	See Attached	
G 159	484.18(a) PLAN OF CARE  The plan of care developed in consultation with the agency staff covers all pertinent diagnoses,	G 159	POC accepted 10/11/12 Susan Emmons RN Francesh Keely RNMSN DBA	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Francis M. Knighton* TITLE: *President/CEO* (X6) DATE: *Oct 8, 2012*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 159	<p>Continued From page 1 including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the agency failed to assure the plan of care included types of visits and treatment required for 1 applicable client. (Client# 1) Findings include:</p> <p>1. Per record review and confirmed through staff interview, the referral and order summary dated 05/23/12 states "monitor vital signs, cardiopulmonary status, nutrition/hydration/elimination, medication effect, reinforce education regarding health issues, home safety, assess wound/incision- daily dressing changes to LLE (left lower extremity, pin site care, monitor pain sleep safety&amp; coping." The treatment plan as noted on the Form 485 (physician's certification) dated 5/23/12 through 7/22/12 does not contain what specific type of dressing change is required for Client #1, nor is there documentation that the physician was consulted that the client be evaluated and educated to do his/her own dressing changes to the LLE.</p> <p>Per interview on 09/24/12 at 4:15 PM the clinical coordinator manager confirmed that the plan of care did not contain specific treatment for the wound or client education for wound management.</p>	G 159	<p><i>See attached</i></p>	
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G 177	<p>484.30(a) DUTIES OF THE REGISTERED NURSE</p> <p>The registered nurse counsels the patient and family in meeting nursing and related needs.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interviews, agency staff failed to counsel 1 applicable client on wound dressing. (Client # 1) Findings Include:</p> <p>Per review of the nursing visit notes dated 06/07/12 the client stated that "the dressing was changed a week ago" and "questioned if s/he was ever going to see a nurse again". Per interview on 09/24/12 at 1:56 P.M. the nurse surveydr asked the admitting nurse if the client was aware of daily dressing changes and was taught how to dress the wound. The nurse stated " I used the stuff (the client) came home with" and " I thought I did, oh well I guess I didn't write it down". In addition, the initial visit notes and assessment dated 05/23/12 contain no evidence that the client was counseled on the daily dressing changes and as to the specific dressings needed.</p>	G 177	<i>See attached</i>		
G 236	<p>also see G-236</p> <p>484.48 CLINICAL RECORDS</p> <p>A clinical recprd containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress</p>	G 236			

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G 236	<p>Continued From page 3</p> <p>notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview the Agency failed to document pertinent information, in accordance with accepted professional standards, in the clinical record for 1 applicable client. (client #1) Findings include:</p> <p>1. Per record review on 09/24/12 for Client #1 who was admitted for services on 05/23/12, the clinical record did not contain specific treatment orders, and had mis-information on the initial assessment and lack of documentation of teaching or response to teaching. Per review of the signed 485 (physician certification) the treatment orders stated daily dressing changes to the left lower extremity, however, however there were no specific interventions noted. The initial assessment on 05/23/12 contained incorrect information under 'M2100-d'- Medical procedures treatment e.g.; changing wound dressing -states a 1- caregiver currently provides assistance. However, the client was identified as living alone and the subsequent nursing visit note states "client is unable to perform [wound dressing] on own secondary to location and pinning ensemble" and "unable to perform, a cousin is available to be taught but unaware if cousin is available all the time". Per interview with the admitting nurse on 09/24/12 at 1:56 P.M. stated " I thought I (taught the client), oh well I guess I didn't write it down". The nurse confirmed that the client did not demonstrate back to the nurse the proper technique but that the client stated ' no problem'</p>	G 236			

*See attached*

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G 236	Continued From page 4 when asked about the dressing. There is no evidence by way of documentation in the clinical record that actual teaching was performed and the response. Per interview the clinical coordinator manager confirmed on 09/4/12 at 4:15 P.M. that the clinical record did not contain pertinent information in accordance with accepted professional standards.	G 236	<i>See attached</i>		

### Edit Note

Customer: **00W, JEFFREY P**  
 Customer ID: **00069341**    SOC: **05/23/2012**    Discharge: **08/08/2012**  
 Admit ID: **00064702**    DOB: **05/15/1963**    Adm Type: **CT**

Category: **CASE COMMUNICATION NOTE**    Author: **JDEVORE**    Search    DEVORE, JENNIFER RN    EMP

Follow-up  
 Due:  11:59 PM    Name:     Search  
 Follow-up completed on:

Note Type: **PA**    Search    PATIENT NOTE - GENERAL  
 Subject: **PATIENT NOTE - GENERAL**

Text:  
 CALL PLACED TO CLIENT HOME ON 6/8/12 AND NO ANSWER OF PHONE OR MACHINE PICK UP. NO AVAILABILITY TO LEAVE A VOICE MAIL. CALL PLACED TO DARTMOUTH AND WAS TOLD THAT CLIENT WAS SEEN IN ER AND DISCHARGED 6/7/12. NEED TO FOLLOW UP ON WHAT CARE SHOULD BE PROVIDED FOR CLIENT'S WOUNDS

Attachment A  
 G143

Entered: 06/10/2012 11:28 AM    By: DEVORE, JENNIFER RN  
 Completed:    By:       

**Wireless Network Connection 2**  
 Click here to process your logon information for the network WVA\_Wireless

**Survey Date 09/24/12**

ID Tag	Plan of Correction	Comp Date	Monitored by
<b>G143</b>	Clinician did not send the case communication note to anyone for follow-up. (See attachment A).	To begin week of October 8, 2012 and ongoing	Director Performance Improvement
	Reinforcement in orientation of need to identify person to follow up on each communication note that is client related.		
	Education to all current staff, reinforcing need to send communication note to a specific individual for follow up.	To be completed October 13, 2012	VP of Clinical Services
	90 day audit of 100% of the previous day/s communication notes will be reviewed on each business day to assure that all client related notes have a follow up person identified.	October 5, 2012 thru January 5, 2013	VP of Clinical Services
<b>G159</b>			
	Professional staff to complete a Care2Learn module regarding documentations requirements on requirements of physician orders and notification to the physician with a change in a client's condition.	To be completed by October 31, 2012	Director Performance Improvement
	Addition of a staff educator who will assist clinical management with joint visits to assess OASIS competency and accuracy.	Begin September 10, 2012	Director of Performance Improvement
	Wound care nurse will review referrals with Pressure Ulcers, Status Ulcers, complicated surgical wounds and wounds requiring daily care for consistency of wound orders and subsequent documentation/orders.	Begin October 8, 2012	VP of Clinical Services and Referral Services

90 day audit of 100% Referral Services will identify new requests for admissions with Pressure Ulcers, Status Ulcers, complicated surgical wounds and wounds requiring daily care and forward referral information to a wound care specialist for review of orders.

Begin October 8, 2012 thru January 8, 2013  
VP of Clinical Services and Referral Services

100% record review for current clients (as of October 8th) with Pressure Ulcers, Status Ulcers, complicated surgical wounds and wounds requiring daily wound care to ensure service provided is in congruency with physician orders.

To be completed by Director of Performance Improvement with October 31, 2012 certified wound care specialists

G177

A minimum of 2 joint visits with clinical manager to observe Pressure Ulcers, Status Ulcers, complicated surgical wounds or wounds requiring daily care wound for care of involved employee.

To be completed by Clinical Manager  
October 13, 2012

Clinical management to continue with joint staff visits to review skills/competencies.

Ongoing Clinical Managers

100% record review for current clients (as of October 8th) with Pressure Ulcers, Status Ulcers, complicated surgical wounds and wounds requiring daily wound care to ensure service provided is in congruency with physician orders.

To be completed by VP of Clinical Services with certified wound care specialists  
October 31, 2012

90 day audit of 30% of SOC home care admissions with Pressure Ulcers, Status Ulcers, complicated surgical wounds and wounds requiring daily care to be sure services provided match those ordered by physician.

October 8, 2012 thru January 8, 2013 Director of Performance Improvement with certified wound care specialists

G236

Clinical management to continue with joint staff visits to review skills/competencies with increased emphasis on assessment and necessity of notifying physician with clinical changes.

Current and ongoing

VP of Clinical Services with Clinical Managers

SOC\ROC OASIS and orders will be reviewed for completeness and accuracy by clinical manager within 1 business day of completion by clinical manager.

Current and ongoing

Clinical Managers

90 day audit of active homecare clients with daily wounds or worsening wounds within 14 days of identification to result in appropriate notification/education.

October 8, 2012 thru January 8, 2013 Director of Performance Improvement with certified wound care specialists

90 day audit of 30% of homecare admissions with Pressure Ulcers, Status Ulcers, complicated surgical wounds and wounds requiring daily care to ensure services provided match those ordered by the physician.

October 8, 2012 thru January 8, 2013 Director of Performance Improvement with certified wound care specialists